A & Z Medical Supplies

Respecting your healthcare needs...

785 S State St
Westerville, OH 43081
Website: aandzmedicalsupplies.com
Phone: 614-776-4445
Fax: 844-643-9306
Email: Info@aandzmedicalsupplies.com

Patient Full Name: _____ Patient DOB: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

City: _____ State:_____ Zip:_____

Male ___ Female___ Email Address: _____

May we leave a message on these numbers? ___Y ____N

PRIMARY INSURANCE: _____

SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____

ID NUMBER: _____ GROUP NUMBER: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: __SELF ___SPOUSE ___CHILD ____DEPENDANT

SECONDARY INSURANCE: _____ PERSON RESPONSIBLE FOR BILL

SUBSCRIBER NAME: _____ **IF NOT PATIENT**

SUBSCRIBER DOB: _____ NAME: _____

ID NUMBER: _____ ADDRESS: _____

GROUP NUMBER: _____ _____

ASSIGNMENT AND RELEASE: I request that payment of authorized Medicare, Medicaid, or insurance benefits be made to **A and Z Medical Supplies** for any services furnished me by this facility. I authorize my medical information to release to Medicare, Medicaid or other insurances to determine benefits or the benefits payable related services to release any medical or other information necessary to process the claim. I also understand that I am financially responsible for payment of services provided. I also acknowledge that I have received a copy of the HIPPA Privacy Practices, a copy of the Patients' Rights Policy and Medicare supplier standards if applicable.

PATIENT SIGNATURE:_____TODAY'S DATE: _____

A & Z Medical Supplies
Respecting your healthcare needs...

785 S State St
Westerville, OH 43081
Website: aandzmedicalsupplies.com
Phone: 614-776-4445
Fax: 844-643-9306
Email: Info@aandzmedicalsupplies.com

Checklist of Information Provided

Customer Name_____ **Date:**_____

Item(s) received:_____

Number of Item(s) received:_____

I have received the following information:

Hours of Operation and How to Contact Us

Rights and Responsibilities

Complaint Procedure / Emergency Preparedness

Patient Privacy Notification

Assignment of Benefits

Equipment Warranty Information

Equipment/Supplies Provided

Educational and instructional materials provided with each item such as a user manual or the educational materials provided by the manufacturer

For Medicare Customers *When Applicable***:**

Inexpensive or Routinely Purchased Items

Capped Rental

ABN (only provided when indicated)

30 CMS Supplier Standards

- Lift Chairs –No returns, No refunds once ordered or delivered.
- I understand that I must contact the doctor of any changes in my condition
- I understand how to use/maintain the product purchased
- I understand that my product purchase has a weight limit.

Signature of Patient or Caregiver **Date**

_____ _____

A & Z Medical Supplies

Respecting your healthcare needs...

785 S State St
Westerville, OH 43081
Website: aandzmedicalsupplies.com
Phone: 614-776-4445
Fax: 844-643-9306
Email: Info@aandzmedicalsupplies.com

Proof of Delivery (Receipt of DME Goods)

Patient name: _____

Delivery address: _____

_____

Delivered to: _____

Date of delivery: _____

Product Name: _____

Brand/Model: _____

Serial Number: _____

Quantity: _____

I certify that I have received the item(s) marked below in good condition. *This equipment is medically necessary and not substandard. This device was sized and fitted and the device fits well. I have received verbal and written instructions for use of the equipment, the warranty, complaint resolution information and the Durable Medical Equipment Supplier Guidelines (except for dressings). We honor all warranties expressed and implied under applicable State law.*

_____ _____ _____

Patient/Guardian/Nurse Date Witness

_____ _____ _____

Delivered by Print Name Signature Date